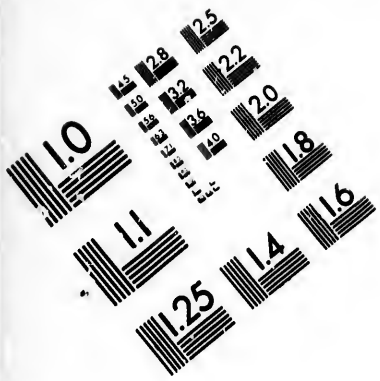

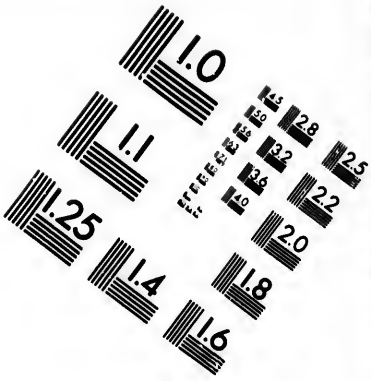

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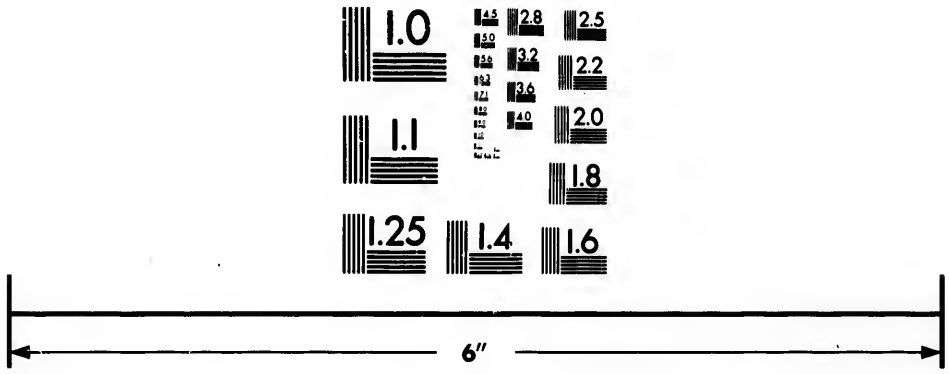

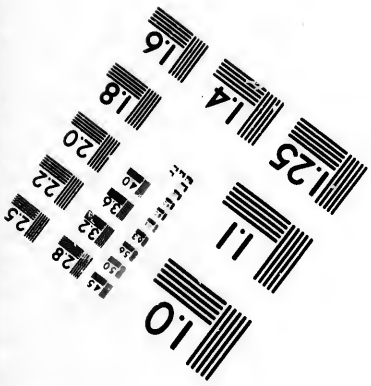

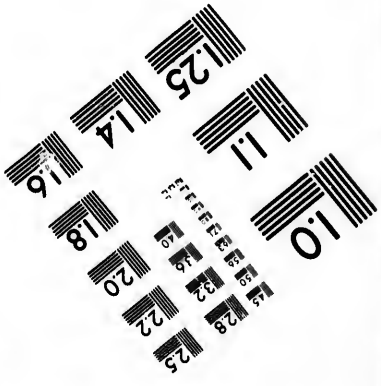

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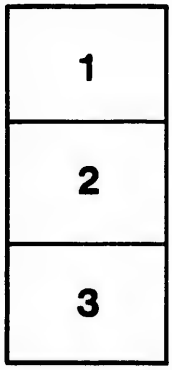

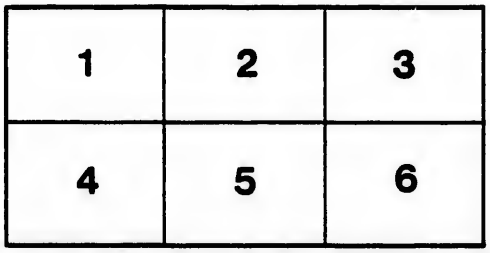

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Keenan, C. B.

A CASE OF TYPHOIDAL CHOLECYSTITIS WITH CHOLELITHIASIS.

BY

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Lecturer on Medicine, McGill University; Assistant Physician, Royal Victoria Hospital.

AND

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Resident Surgeon, Royal Victoria Hospital.

(*Reprinted from the Montreal Medical Journal, December*, 1897.)

A CASE OF TYPHOIDAL CHOLECYSTITIS WITH CHOLELITHIASIS.[1]

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Resident Surgeon, Royal Victoria Hospital.

Cases of typhoidal infection of the gall-bladder are, on the whole, not so very uncommon, and during the present year not a little attention has been paid to them in the recent papers of Dr. Osler and Dr. Mason at the last annual meeting of the Association of American Physicians. So far as we are aware, however, no cases of the kind have been brought to the notice of this Society, and the present communication is presented, inasmuch as its clinical interest is certainly worthy of some attention. The following are the notable features :

1. A suppurative cholecystitis in the course of typhoid fever and originating from the presence of typhoid bacilli in pure culture in the gall-bladder.

3. The difficulties and special features of diagnosis of an infected gall-bladder complicating typhoid fever.

3. The mode in which the complication affects the course of the malady.

4. The means of treatment and the effects of the complication.

The patient concerned was a female, aged 35, a typewriter by occupation. She was admitted to the Royal Victoria Hospital on the 21st of September, having been treated previously for nearly three weeks by Dr. Deeks. Her symptoms during that time had been not unlike those of enteric fever, viz., general malaise, insomnia, remittent fever, enlarged spleen and gastro-intestinal disturbances.

On the day previous to admission, however, diarrhœa set in with clay-coloured stools. There was severe pain in the abdomen, referred to the right side near the umbilicus, the temperature within a very few hours dropped from 102° to 98°, and the pinched facies expressed great anxiety. The pulse, however, was good and not notably increased in rapidity.

[1] The present case occurred while the Retrospect on similar conditions which appears in this number was being written.

Professor Stewart, who saw the case in consultation, advised her removal to the hospital, and described the condition then somewhat as follows :

The temperature was 98⅘°, pulse 90, and the respirations 24 per minute. She was poorly nourished, evidently suffered intermittent pain, had a grayish coated tongue, anorexia, and the diarrhœa above described. There was no jaundice. Examination of the abdomen revealed slight redness over the right hypochondrium and a scarcely perceptible œdema. Pressure on the ribs induced tenderness, but no friction rub could be felt on palpation. Immediately below the ribs, a large mass was detected continuous with the liver and extending down as far as 2 to 3 cm. below the umbilicus, situated towards the median line and its right border slightly external to the right rectus muscle. Percussion over this area produced a modified dullness with some slight tympany From above downwards the hepatic dulness began at the 6th rib. Pressure behind gave slight tenderness in the right line, but elsewhere there was no evidence of disease. The urine showed a trace of albumen, but no bile. The blood on examination for the Pfeiffer test, both at the laboratory of the Royal Victoria Hospital and at the General Hospital gave a positive reaction for typhoid. For the next three days the condition remained comparatively unaltered, except slightly increased rigidity and distension : surgical interference being deemed advisable Doctors Garrow, Bell and Roddick were consulted, and the questions of diagnosis and treatment considered. While it was comparatively easy to exclude impaction of fæces, affections of the kidney and perforation from typhoid, the question of subcutaneous phlegmon, appendicitis and infection of the bile passages gave rise to considerable hesitation in the diagnosis. That cellulitis was present seemed more than likely from the marked œdema which had gradually developed in the abdominal wall ; while, at the same time, some more deeply-seated condition was also judged to be present. The mass itself, apart from the presence of what seemed a tongue of liver tissue coming down in the right hypochondrium, could not be definitely defined, and no distinct fluctuation was apparent. The symptoms, with the clinical history, pointed rather to some infection of the gall bladder than to appendicitis. The ultimate diagnosis was that of cholecystitis and cholelithiasis and operation was urged.

An incision was made in the right semi-lunar line, and the distended gall-bladder exposed lying amid a quantity of lymph due to a local plastic peritonitis. Adhesions of the gall-bladder were observed on all sides, but as yet no perforation of the organ had taken place.

Upon tapping, turbid grayish-green fluid was removed, and subsequently the gall-bladder itself was incised, and 150 small facetted cholesterin calculi were removed. The margin of the artificial opening in the gall-bladder was next stitched to the peritoneum and the usual surgical toilet performed.

The patient, however, failed to recover well from the operation, and at the end of the second day succumbed to the disease. Only a partial autopsy was permitted, but sufficient to show the typical lesions of typhoid fever in the intestines and the subacute inflammation of the gall-bladder itself with the more or less subacute pericholecystitis.

Cultures were obtained at operation from the gall-bladder and micro-organisms obtained which responded to all the tests for the B. typhosus. The fluid itself when examined in the fresh state revealed actively motile bacilli which agglutinated and became stationary when brought into contact with the blood serum of a patient affected with typhoid fever. The bacilli when later cultivated gave the same reaction of Pfeiffer, thus establishing beyond a doubt the identity of the microbe present in the gall-bladder. In addition to our own investigations, Dr. J. G. Macdougall made entirely independent tests and likewise identified the bacteria as those of enteric fever in pure culture.

In orienting ourselves again as to the special features in the diagnosis, there are several which in a way were seemingly characteristic.

The sudden alteration in the course of the disease, with development of a subnormal temperature, and sudden pain in the abdomen might have suggested perforation of the intestine, but the pulse remaining quiet and strong this was practically excluded. The symptoms, too, were intermittent, with periods of comparative freedom from pain and anxiety, which too has been a feature prominent in many similar cases of typhoidal cholecystitis. Add to this the tongue of liver pulled down by the gall-bladder, as first shown by Riedl, and we have a series of suggestive symptoms for the diagnosis. Jaundice was, of course, not to be expected as the bile passages elsewhere remained free.

The question of operation, while always a grave matter in cases of typhoid fever, was here a positive necessity, and from the thinned condition of the gall-bladder wall had undoubtedly anticipated an impending perforation. While the case recorded by Mason of successful tapping of the gall-bladder in a somewhat similar instance is of remarkable interest, yet the presence of calculi in our own case necessitated a more radical means of treatment.